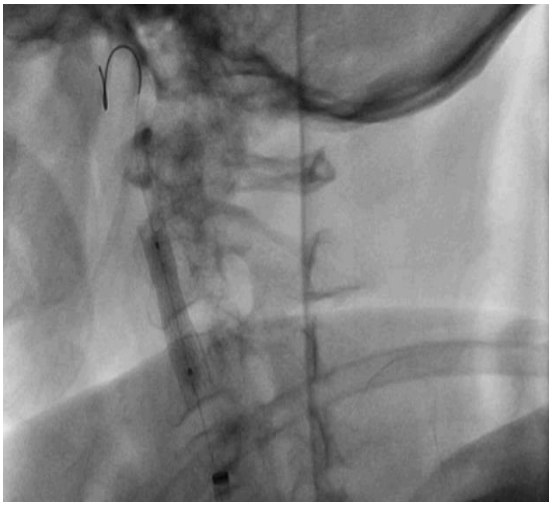
55 years old patient known case of coronary artery disease, hypertension, diabetes mellitus type II presented with recurrent right hemiparesis with three episode in the past and difficulty in speech. She had right spastic hemiparesis more in upperlimb than lower limb. On examination patient conscious, alert and oriented, pulse 88/min, regular, Blood pressure 146/90 mm of Hg, . Right upper limb and lower limb tone increased. Power in right upper limb and lower limb 2/5.

Coronary and Carotid angiogram done which showed Right coronary mild disease, right ICA mild disease, left ICA shows 95% stenosis with ulcerated plaque. After informed consent left carotid artery cannulated with JR 5F guiding catheter and exchanged with 7F Shuttle sheath. Then left ICA lesion was crossed with 0.014” x 180 cm run-through wire and Spider FX 6 mm filter positioned in distal carotid. Pre dilatation done with 3 x 20 mm maverick balloon after premedicaion with atropine. Later 6-8 x 30 mm tapered x-act stent deployed across stenotic lesion with good result. At the time of discharge right upper limb power 3/5 and Lower limb power 4/5.



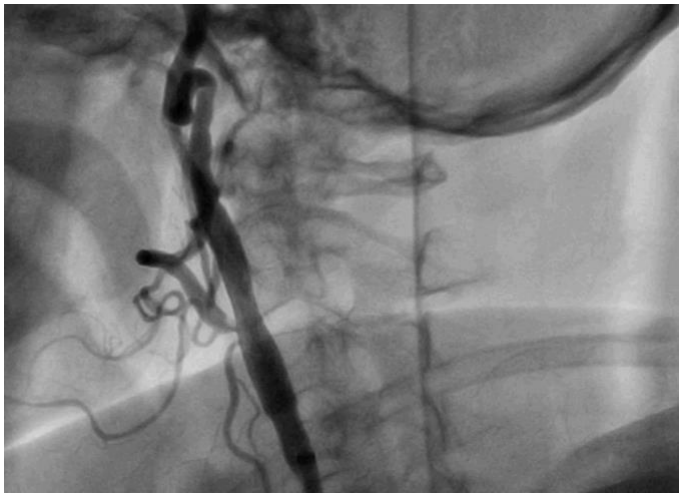


Table 6 2018 ESVS recommendations for managing patients with asymptomatic carotid artery disease[28]

In 'average surgical risk' patients with an asymptomatic 60%–99% stenosis, CEA should be considered in the presence of 1+ imaging characteristics that may be associated with an increased risk of late ipsilateral stroke*, provided perioperative stroke/death rates are <3% and the patient's life expectancy exceeds 5 years.	Class IIa	Level B
In 'average surgical risk' patients with an asymptomatic 60%–99% stenosis in the presence of 1+ imaging characteristics that may be associated with an increased risk of late ipsilateral stroke*, CAS may be an alternative to CEA, provided perioperative stroke/death rates are <3% and the patient's life expectancy exceeds 5 years.	Class IIb	Level B
CAS may be considered in selected asymptomatic patients who have been deemed by the multidisciplinary team to be 'high-risk for CEA' and who have an asymptomatic 60%–99% stenosis in the presence of 1+ imaging characteristics that may be associated with an increased risk of late ipsilateral stroke*, provided procedural risks are <3% and the patient's life expectancy exceeds 5 years.	Class IIb	Level B

*See table 5 for clinical/imaging features.
The colour of the text boxes identifies the class and level of evidence.
CAS, carotid artery stenting; CEA, carotid endarterectomy; ESVS, European Society for Vascular Surgery.

Table 3 2018 ESVS recommendations for managing patients with symptomatic carotid artery disease[28]		
CEA is recommended in patients reporting carotid territory symptoms <6 months and who have a 70%–99% carotid stenosis, provided the documented procedural death/stroke rate is <6%.	Class I	Level A
CEA should be considered in patients reporting carotid territory symptoms <6 months and who have a 50%–69% carotid stenosis, provided the documented procedural death/stroke rate is <6%.	Class IIa	Level A
It is recommended that most patients who have suffered carotid territory symptoms <6 months and who are aged >70 years and who have 50%–99% stenoses should be treated by CEA, rather than by CAS.	Class I	Level A
When revascularisation is indicated in patients who with carotid territory symptoms <6 months and who are aged <70 years, CAS may be considered an alternative to CEA, provided procedural death/stroke rates are <6%.	Class IIb	Level A
When revascularisation is considered appropriate in symptomatic patients with 50%–99% stenoses, it is recommended that this be performed as soon as possible, preferably within 14 days of symptom onset.	Class I	Level A
Patients who are to undergo revascularisation within the first 14 days after onset of symptoms should undergo CEA, rather than CAS.	Class I	Level A
In recently symptomatic patients with 50%–99% stenoses and anatomical and/or medical comorbidities that are considered by the multidisciplinary team to make them 'higher-risk for CEA, CAS should be considered as an alternative to endarterectomy, provided the documented procedural death/stroke rate is <6%.	Class IIa	Level B

The colour of the text boxes identifies the class and level of evidence.
CAS, carotid artery stenting; CEA, carotid endarterectomy; CREST, Carotid Revascularisation versus Stenting Trial; ESVS, European Society for Vascular Surgery.

Table 2: Risk Factors to Consider When Choosing Procedures

High Risk for CEA		High Risk for CAS	
Surgical Anatomy	Comorbidities	Vessel Anatomy	Plaque Characteristics
Previous CEA or neck surgery	Severe CHF	Type II or III aortic arch	Lipid rich plaque
Presence of tracheostomy	Severe CAD	Aortic arch disease	Intraplaque haemorrhage
Previous radiation	Severe pulmonary disease	Tortuosity of ICA or CCA	Calcified plaque
Contralateral occlusion	Renal Failure	Occlusive disease of access vessels	Thin fibrous cap
Laryngeal nerve palsy			Lesion located at a curve
Lesion extending above C2 vertebra			Extensive plaque

CAD = coronary artery disease; CAS = carotid artery stenting; CCA = common carotid artery; CEA = carotid endarterectomy; CHF = coronary heart failure; ICA = internal carotid artery.

Complications.

Cardiovascular

-vasovagal reactions(5-10%)

-MI(1%)

Carotid Artery

-dissection(<1%)

-Thrombosis(<1%)

-Perforations (<1%)

-ECA restenosis or occlusion (5-10%)

-Restenosis(3-5%)

Neurological

-TIA (1-2%)

-Stroke (2-3%)

-Intracranial hemorraghe (<1%)

Hyperperfusion syndrome (<1%)

Death 1%.

TABLE 7: Recommendations for carotid artery stenting

Recommendation	Class	Level
The use to embolic protection devices should be considered in patient undergoing CAS	IIa	B
Proximal protection devices are not recommended in patients with advanced common carotid disease, or those with external carotid artery disease (where an occlusion balloon is to be positioned in the external carotid artery) or in patients with contralateral occlusion and insufficient collateralization	III	C

CAS, carotid artery stenting.